State/Territory California

Citation | Condition or Requirement

**REIMBURSEMENT FOR SHORT-DOYLE/MEDI-CAL**

**OUTPATIENT, REHABILITATIVE, CASE MANAGEMENT AND OTHER SERVICES**

The policy of the State Agency is that reimbursement for Short-Doyle/Medi-Cal services shall be limited to the lowest of published charges, Statewide Maximum Allowances (SMAs), negotiated rates, or actual cost if the provider does not contract on a negotiated rate basis. To provide mutually beneficial incentives for efficient fiscal management, providers contracting on a negotiated rate basis shall share equally with the Federal Government that portion of the Federal reimbursement that exceeds actual cost. In no case will payments exceed SMAs.

**A. DEFINITIONS**

"Published charges" are usual and customary charges prevalent in the public mental health sector that are used to bill the general public, insurers, and other non-Title XIX payors. (42 CFR 447.271 and 405.503(a))

"Statewide maximum allowances" are upper limit rates, established for each type of service, for a unit of service. Units of service are defined as patient days for residential programs, half-days or full-days for day services, blocks of four hours for crisis stabilization services, and minutes for all other program services.

"Negotiated rates" are fixed, prospective rates of reimbursement, subject to the limitations described in the first paragraph above.

"Actual cost" is reasonable and allowable cost, based on year-end cost reports and Medicare principles of reimbursement as described at 42 CFR Part 413 and in HCFA Publication 15-1.

"Provider" means each legal entity providing Short-Doyle/Medi-Cal services.

"Legal entity" means each county mental health department or agency and each of the corporations, partnerships, agencies, or individual practitioners providing public mental health services under contract with the county mental health department or agency.

B. **REIMBURSEMENT METHODOLOGY FOR NON-NEGOTIATED RATE PROVIDERS**

REIMBURSEMENT LIMITS

The reimbursement methodology for non-**NEGOTIATED RATE PROVIDER** Short-Doyle/Medi-Cal services, by legal entity, is based on the lowest of:

1. The provider's published charge to the general public, unless the provider is a **NOMINAL CHARGE PROVIDER** (as defined below).

2. The provider's allowable cost.

3. The SMAs established as defined in Section D. by the Department of Mental Health (DMH) and approved by the Department of Health Services (DHS).

The above reimbursement limits are applied at the time of settlement of the year-end cost report after determination of Nominal Charge status and are applied individually to each legal entity providing services. For hospital providers, reimbursement is determined separately for inpatient and outpatient services. Reimbursement is based on comparisons of total, aggregated allowable costs after application of SMAs to total, aggregated published charges, by legal entity, computed separately for inpatient and outpatient services but without further distinction between different types of outpatient services.

NOMINAL CHARGE PROVIDER

Determination of Nominal Charge status is the first step in the cost report settlement process, before application of reimbursement limits. Pursuant to Medicare rules at 42 CFR 413.13, public providers and non-public providers with a significant portion of low-income patients are reimbursed the lower of actual cost or SMAs if total charges are 60 percent or less of the reasonable cost of services represented by the charges. The determination of nominal charges for outpatient, rehabilitative, case management, and other services is made in accordance with, and by extension from, Medicare inpatient rules at 42 CFR 413.13(f)(2)(iii). For

hospital providers, the determination is made separately for inpatient and outpatient services. The determination is based on comparisons of total, aggregated actual costs to total, aggregated published charges, by legal entity, computed separately for inpatient and outpatient services but without further distinction between different types of outpatient services.

## C. REIMBURSEMENT METHODOLOGY FOR NEGOTIATED RATE PROVIDERS

REIMBURSEMENT LIMITS

The reimbursement methodology for **NEGOTIATED RATE PROVIDER** Short-Doyle/Medi-Cal services, by legal entity, is based on the lowest of:

1. The provider's published charge to the general public, unless the provider is a **NOMINAL CHARGE PROVIDER** (as defined below),

2. The provider's negotiated rates, based on historic cost, approved by the State,

3. The SMAs established as defined in Section D. by the DMH and approved by the DHS.

The above reimbursement limits are applied at the time of settlement of the year-end cost report after determination of Nominal Charge status and are applied individually to each legal entity. The methodology is the same as in Section B except that the Negotiated Rates are construed to be actual costs. If reimbursement to a negotiated rate provider exceeds actual costs in the aggregate, 50 percent of the Federal Financial Participation (FFP) that exceeded actual costs will be returned to the Federal government.

NOMINAL CHARGE PROVIDER

Determination of Nominal Charge status is the first step in the cost report settlement process, before application of reimbursement limits. Pursuant to Medicare rules at 42 CFR 413.13, public providers and non-public providers with a significant portion of low-income patients are reimbursed the lower of negotiated rates or SMAs if total charges are 60 percent or less of the reasonable cost of services represented by the charges. The determination of nominal charges for outpatient, rehabilitative, case management, and other services is made in accordance with, and by extension from, Medicare inpatient rules at 42 CFR 413.13(f)(2)(iii).

For hospital providers, the determination is made separately for inpatient and outpatient services. The determination is based on comparisons of total, aggregated actual costs to total, aggregated published charges, by legal entity, computed separately for inpatient and outpatient services but without further distinction between different types of outpatient services.

D. SMA METHODOLOGY

The SMAs are based on the statewide average cost of each type of service as reported in year-end cost reports for the most recent year for which cost reports have been completed. County administrative and utilization review costs are isolated and not included in the direct treatment payment rates. After eliminating rates in excess of one standard deviation from the mean, the top ten percent of providers with the highest rates are eliminated from the base data to afford cost containment and allow for an audit adjustment factor. The total costs of each type of service are then divided by the total units of service to arrive at a statewide average rate. The adjusted average rates are inflated by a percentage equivalent to the Home Health Agency Market Basket Index for the period between the cost report year and the year in which the rates will be in effect.

The State Fiscal Year 1989-90 cost report data was used to develop base rates. The rates from the base year were adjusted for inflation annually by applying the Home Health Agency Market Basket Index. When the SMAs are re-based, the data will be adjusted to reflect the lower of actual costs or the SMA's in effect for the base year.

The SMAs for crisis stabilization, adult crisis residential treatment, and adult residential treatment are provisional because these are new services not included in the current database. The SMA for crisis stabilization is based on a cost survey of fourteen county programs that provide services for up to 24 hours in an emergency room setting. The SMAs for the two residential programs are based on a cost survey for approximately sixty facilities and include reimbursement only for treatment; room and board costs are excluded. No Federal funds will be used for IMD services. All three provisional rates will be reviewed and rebased for State Fiscal Year 1995-96 based on State Fiscal Year 1993-94 cost report data.

The SMA for psychiatric health facilities is also provisional and new for State Fiscal Year 1994-95. The SMA is based on a cost survey of six county programs which provide rehabilitative services in a non-IMD 24-hour environment. Room and board costs are excluded. The provisional SMA will be reviewed and rebased for State Fiscal Year 1996-97 based on State Fiscal Year 1994-95 cost report data.

## E. ALLOWABLE SERVICES

Allowable outpatient, rehabilitative, case management, and other services and units of service are as follows:

| Service | Unit of Service |
|---|---|
| Day Treatment Intensive | Half-day or Full-Day |
| Day Rehabilitative | Half-day or Full-Day |
| Mental Health Services | Single Minutes |
| Medication Support | Single Minutes |
| Crisis Intervention | Single Minutes |
| Crisis Stabilization | One-Hour Blocks |
| Case Management/Brokerage | Single Minutes |
| Adult Crisis Residential Treatment | Day (Excluding room and board) |
| Adult Residential Treatment | Day (Excluding room and board) |
| Psychiatric Health Facility | Day (Excluding room and board) |

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REIMBURSEMENT FOR MEDI-CAL PERSONAL CARE SERVICES

A. REIMBURSEMENT PRINCIPLES

(1) It is the Department's policy, subject to the specific provisions set forth below and except as provided in paragraphs E and F, that reimbursement rates for Personal Care Services shall not be less than levels necessary to achieve adequate access to these services, but shall not exceed the lesser of specified limits, consistent with the requirements of Section 1902(a)(30)(A) of the Social Security Act.

(2) Paragraphs G and H, below, shall not apply to services provided in the manner specified in paragraphs E or F.

B. DEFINITIONS

(1) "Usual and Customary Charges" means the average or prevalent charge billed by the provider to the general public, insurers, or other non-Title XIX payors.

(2) "Schedule of Maximum Allowances" (SMA) means the maximum payment rates established for each unit of service. A unit of service is defined as a patient service hour or fraction or multiple thereof rendered to beneficiaries of Personal Care Services.

(3) "Medicare Maximum Allowances" are the reimbursement rates that are/would be made to providers of Personal Care Services by the federal Medicare Program.

(4) "Personal Care Services" are those services defined in Section 51183, Title 22, Division 3, California Code of Regulations.

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(5) "In-Home Supportive Services" means the program defined in Section 12300 et seq. of the Welfare and Institutions Code.

(6) "Public authority" and "nonprofit consortium" mean the entities defined in Section 12301.6 of the California Welfare and Institutions Code.

(7) "Individual provider" means that individual described in Section 51181, title 22, Division 3, California Code of Regulations, who provides services under the Personal Care Services Program. (See Cal. Code Regs., tit. 22, § 51204(a).)

(8) "Personal care services provided under contract" means those services provided by a contractor under a contract with the county, but does not include a contract entered into pursuant to California Welfare and Institutions Code section 12302.7.

C. ADMINISTRATIVE PROCESS

Personal Care Services program reimbursement rates shall be subject to the general provisions of the section of this Attachment 4.19-B that is entitled, "Reimbursement Limits for Professional Services", commencing at page 1 hereof.

D. FUNDING

(1) To the extent that the Department finds that sufficient access to services is available, any rate increases granted under this program shall be no greater than the funds appropriated by the Legislature for such purpose, except as provided in paragraph D(2), below.

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(2) If the funds appropriated by the Legislature do not include an increase for reimbursement rates for providers of personal care services sufficient to cover the increases recommended by the Department pursuant to the provisions of this section of the State plan, a county may use county-only funds to meet federal financial participation requirements, subject to specific provisions of this section of the State plan and subject to the Department's determination that the requirements of federal law have been complied with, including but not limited to the requirements of 42 Code of Federal Regulations, section 433.51.

E. REIMBURSEMENT RATE LIMITATIONS FOR PERSONAL CARE SERVICES PROVIDED UNDER CONTRACT

(1) A county may contract with a city, county, or city and county agency, a local health district, a voluntary nonprofit agency, a proprietary agency, or an individual for the purpose of providing personal care services.

The cost of the service will not exceed by more than 10 percent the allowable cost of the service as determined by the State Department of Health Services, in consultation with the State Department of Social Services.

The rate of reimbursement shall be negotiated consistent with applicable regulations promulgated by the State Department of Social Services or the State Department of Health Services. For any contract extended beyond the first contract term, the rate shall reflect, but is not limited to, the following financial considerations:

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(a) Actual expenditures by the contractor as documented during the first contract term and approved by the state.

(b) Changes in federal, state, or county program requirements.

(c) Federal and state minimum wage and contractual step merit increases.

(d) Statutory taxes.

(e) Insurance costs.

(f) Reasonable costs which have been approved by the county department of social services, as long as those costs do not increase unreimbursed county expenditures or lead to a reduction in client services, and those costs can be funded within the maximum allowable rates set by the State Department of Social Services for in-home supportive services contracts and the county's state allocation for in-home supportive services.

(g) Other reasonable costs over which the contracting parties have no control.

Applicable regulations promulgated by the State Department of Social Services and the State Department of Health Services will also establish standards governing acceptable contract provisions, the methods used to advertise, procure, select and award the contracts, and the procedures used to amend, renew, or extend an

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existing contract with the same contractor including, in addition to rate changes, any other change in other terms of the contract.

(2) In addition, all contracts are subject to the following:

(a) Prior to initiating a contract or contracts, the county will publicize its intention to solicit bids to enter into the contracts.

(b) When the county has selected one or more contract proposals for tentative acceptance or intends to renew an existing contract, the county board of supervisors will conduct a hearing on the proposed contract, contracts, or renewal, which will be at a regularly scheduled meeting of the board of supervisors, and open to the public.

(c) Public findings based on the public hearing will be made available to interested parties.

(d) No contract will take effect until 30 calendar days have elapsed from the time of the public hearing required under this section.

(e) The county board of supervisors may award one or more contracts based upon the fiscal responsibility of the service providers and the experience of the service providers in providing services. The county board of supervisors may evaluate the bid proposal, the experience of the provider, the program plan, and the proposed contract rate, to determine if a bidder has demonstrated the ability to reasonably provide and sustain uninterrupted,